

LETTER OF PUBLIC COMMENT
APCD POLICIES AND PROCEDURES

September 10, 2013

Introduction

The Health Disparities Institute and the undersigned organizations and people are deeply committed to and supportive of Connecticut's goal of eliminating racial, ethnic and other disparities in healthcare. We have reviewed the *Draft APCD Policies and Procedures*, including the *Data Submission Guide* (DSG), and submit comment with a focus on propelling the state towards health equity while preserving citizen privacy. We do so in the context of the public policy decision made by the legislature and signed by the Governor into law via Public Act 13-247 to site the APCD within Access Health CT.

Consequently, our comments are targeted toward meeting the guiding principles¹ of Access Health CT, adopted by the Access Health CT Board of Directors, the first of which is “an exceptional consumer experience” as demonstrated in part through: **“A level playing field – the Exchange should work to address longstanding, unjust disparities in health access and outcomes in Connecticut.”**

Our comments are also consistent with Access Health CT's guiding principle of transparency: “All Exchange activities should be open to the public, its services easily available, and its information easily understood by the population it assists.”

In stark contrast to indicators of wealth and progress in our state, poor health outcomes are found among Black/African-American, Latino and other racial-ethnic groups, persons with disabilities, sexual and gender minorities, the urban and rural poor, and other socially and economically disadvantaged groups.² Disparities in access, quality of care, and outcomes shorten life expectancy, reduce quality of life, and weaken our state's economy. A rough estimate of the cost of minority related health disparities to Connecticut's economy is \$800 million per year.³ This economic burden impacts taxpayers, employers that pay for employee health coverage and patients that pay out of pocket for healthcare services.

It is unlikely that health disparities will be eliminated without access to data that identifies the demographic factors associated with access and use of healthcare services, as well as the cost, quality, and outcome of services provided to specific populations. Access to APCD data is necessary to enable targeted outreach and

¹ Access Health CT Guiding Principles. Retrieved from: <http://www.ct.gov/hix/cwp/view.asp?a=4295&Q=506732>

² Hynes, M.M. (2011). *The Landscape of Health Disparities in Connecticut*. Connecticut Department of Public Health. Retrieved from: http://www.ct.gov/dph/lib/dph/hisr/pdf/landscape_healthdisparitiesct2011.pdf

³ Based on calculation used in the state of Maryland. Mann, D.A. (2009). *Cost of Disparity Analysis & Using Disparity Data for Policy*. Office of Minority Health and Health Disparities Maryland Department of Health and Mental Hygiene. Retrieved from <http://marylandhbe.com/wp-content/uploads/2013/04/Health-Reform-is-a-Minority-Health-Project-in-Maryland.pdf>

intervention, quality of care improvements, culturally and linguistically competent care, and policy and practice interventions to eliminate health disparities.

Simply put, in order for Access Health CT to abide by its guiding principle to level the playing field, the *APCD Policies and Procedures* and *DSG* must require submission of the types of data that allow for the playing field to be leveled.

Comments on specific provisions of the Connecticut Health Insurance Exchange's *Draft Policies and Procedures: All-Payer Claims Database*:

Definitions

1. We take issue with the narrow definition of claims as “paid” claims and propose denied claims data also be submitted to the APCD and be available for relevant policy, programmatic analysis, and public reporting. Denied claims are potential indicators of barriers to access amongst those with insurance. If adopted as drafted, these policies and procedures will unnecessarily limit ascertainment of the extent to which some populations experience more denied claims and higher out-of-pocket expenses than other populations (e.g. more educated, English-speaking people with jobs that allow phone calls during insurance company customer service hours versus less educated, non-English speaking people, with jobs that don't allow phone calls during insurance company customer service hours). This is an indicator of health equity.

Failure to include denied claims data is inconsistent with assuring the transparency of healthcare data envisioned in the authorizing legislation for the APCD. Further, the lack of language in legislation restricting the collection of data to paid claims is further evidence that there was no intent to eliminate denied claims data from submission to the APCD.⁴

2. We also take issue with the narrow definition of “member” and propose that no exceptions be made to the reporting of claims and demographic data for members based on the funding method, risk adjustment requirement, or grandfathering exclusions for the health insurance plan the member is enrolled in. If adopted as proposed, these policies and procedures appear to prevent transparency of cost, quality, and equity data for more than half⁵ (i.e. self-insured plan enrollees) of our state's insured population thereby thwarting meaningful analyses and policy efforts to improve our health system. As written, the drafted definition of member is inconsistent with enabling statutes as well as Access Health CT guiding principles.

Reporting Requirements

⁴ Conn.Gen.Stat. §19a-724b, as amended by Public Act 13-247, section 144, and Conn.Gen.Stat. §38-1084, as amended by Public Act 13-247, section 138.

⁵ CT Health Policy Project; *Basics of Health Policy*, May 2013. Retrieved from http://www.cthealthpolicy.org/pdfs/health_policy_basics.pdf

Similar to other listed data files, we propose that each Reporting Entity shall also submit Eligibility Data Files for any enrollment/eligibility processed by any sub-contractor on the Reporting Entity's behalf. Eligibility Data Files contain demographic data necessary to stratify healthcare utilization by socioeconomic factors to identify health disparities across different populations. If the intention of the Exchange is to require Reporting Entities to submit eligibility data on all members, including those managed by subcontractors, the *Draft APCD Policies and Procedures* language should be modified to make this explicit.

We take issue with the granting of a waiver to a subcontractor that "can demonstrate" that its submission would be duplicative. Notwithstanding that the word "duplicative" is not defined in this context, an affirmative demonstration that shows the submission is "identical" would be necessary to ensure the level of accuracy of eligibility data and to preserve the integrity of the APCD.

Reporting Entities Data Submission Schedule

1. Waivers for particular data submission requirements may affect the intended usability of data to provide health care consumers and policymakers with information regarding cost and quality of healthcare services to minority and underserved populations, as well as data availability to state agencies, employers, health care providers and researchers for the purpose of designing programs and policies aimed at attaining health equity.

2. We take issue with any waiver authority by the APCD Administrator and propose instead a process that includes the APCD Advisory Council or similar governing body as well as the opportunity for public comment. Specifically, we take issue with the granting of waivers for health disparities centric data elements such as race, ethnicity, and language. Such waivers could disable health system innovations and initiatives to identify, assess, and eliminate health disparities and are inconsistent with the guiding principles of Access Health CT to level the playing field.

3. In the alternative, were such waivers to be granted upon review by the APCD Advisory Council, we propose the Exchange require the Reporting Entity conform to data submission requirements within a specified period of time or face a penalty.

Non-Compliance and Penalties

1. We support the authority of the Exchange to conduct audits of data submitted to the APCD by Reporting Entities to verify the accuracy of data. We propose audits additionally verify the completeness of submitted data. We further propose that such audits not be optional (i.e. replace the word "may" with "shall"), and that a plan be developed for cyclical audits to ensure data integrity.

2. We support the authority of the Exchange to issue notices and impose civil penalties on non-compliant Reporting Entities. We propose that such regulatory steps not be optional (i.e. replace the word "may" with "shall"), including providing the name of the Reporting Entity on which a penalty was imposed to the Insurance Commissioner.

3. Similarly, we support the authority of the Insurance Commissioner to request the Attorney General bring actions to recover imposed penalties from non-compliant Reporting Entities and propose this regulatory step not be optional (i.e. replace the word “may” with “shall”).

4. We propose the Exchange incorporate its standards for completion and accuracy of Reporting Entity data submissions in its *Draft Policies and Procedures*, and that the Exchange make public Reporting Entity performance in relation to data completion and accuracy standards. Public reporting by Access Health CT on Reporting Entity performance is consistent with the Exchange’s guiding principle on transparency and sound public policy.

Data Utilization and Disclosure

1. Pursuant to plain language in the governing statutes, we take issue with the Exchange unilaterally determining data availability to consumers and public and private entities engaged in reviewing health care utilization, cost, or quality of healthcare services, including community and public health assessment activities.

2. We further raise our concern that the Exchange does not specifically address the statutory requirement that it make data widely available. We propose an approach that involves the APCD Advisory Council in the development of meaningful reports for consumers and the development of a process for data access, utilization and disclosure, including a data extract request process, similar to other APCD states. We further propose a third party appeal process for denied data access requests.

Section 144 of Public Act 13-247 requires:

The exchange **shall**: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. Such disclosure shall be made in accordance with subdivision (2) of subsection (b) of section 38a-1090 of the general statutes, as amended by this act.

3. If adopted as drafted, APCD policies and procedures potentially keep from public view the very data that is meant to be made transparent through the establishment of the state’s APCD with federal funds. Access to data contained in the APCD is necessary to enable targeted outreach and intervention, quality of care improvements, culturally and linguistically competent care, and policy and practice interventions to eliminate health disparities.

Privacy and Confidentiality

1. We support the Exchange making data available consistent with HIPAA regarding the safeguarding of Protected Health Information and the de-identification of data, and in compliance with state and federal data security and confidentiality requirements. We

propose the Exchange either confirm the DSG, as proposed, is compliant with stated privacy and confidentiality requirements or identify data elements that are determined noncompliant in the Revised DSG for public comment.

2. We take issue with the suggestion that it is optional to make de-identified data available for review by public and private entities designated in the plain language of governing statute, “any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services” (i.e. replace the word “may” with “shall”).

Comments on revision of Connecticut Health Insurance Exchange’s *Draft Policies and Procedures: All-Payer Claims Database*:

Prior to notifying Reporting Entities and posting a Revised Draft for public comment, we propose the Exchange consider all submitted public comments, publish public comments in a conspicuous location on its website, and provide the APCD Advisory Council its rationale for including or excluding revisions. We propose the APCD Advisory Council review, approve, modify, or reject proposed revisions and that the Exchange not proceed with such revisions unless the APCD Advisory Council and the Access Health CT Board approve such changes by vote.

Comments on specific provisions of *Access Health CT Connecticut All-Payer Claims Database Draft Data Submission Guide (DSG)*:

DSG Data Elements - Eligibility

1. We support the inclusion of health disparities centric data elements including gender, age/date of birth, zip code, primary race, secondary race, other race, primary ethnicity, secondary ethnicity, other ethnicity, Hispanic status indicator, verbal language preference, other language preference, medical home indicator, marital status, employment status, disability indicator, interpreter, and Access Health CT indicator to enable stratification of health utilization data to identify health disparities across populations as well as to measure the Exchange’s impact on reducing health insurance coverage disparities for communities of color.

2. We take issue with the DSG element submission guideline language that fails to encourage the collection of race, ethnicity, and language data elements: “Do not report any value here if data has not been collected. Report only collected data”. This language does not appear anywhere else in the submission guide, is used solely in reference to the collection of race, ethnicity, and language data, and is inconsistent with the guiding principles of Access Health CT to level the playing field. We propose the current language be struck from the document.

3. We propose the Exchange require Reporting Entities and enrollment subcontractors enable voluntary self-reporting of data elements such as race, ethnicity, and language at the point of enrollment, or provide a time-bound plan for compliance, whether enrollment is via paper, telephone, or online. Anything less is inconsistent with the Exchange’s adopted guiding principle of addressing health disparities and disables the

identification, reduction, and elimination of health disparities envisioned at the federal and state levels, including Connecticut's innovation efforts.

4. Access Health CT and the APCD are federally supported initiatives. Under Section 4302 of the Affordable Care Act, the [HHS] Secretary is required to ensure that any federally conducted or supported health care or public health program, activity or survey collects and reports data, to the extent practicable, on race, ethnicity, sex, primary language and disability status, as well as other demographic data on health disparities as deemed appropriate by the Secretary.⁶

5. A review of federal laws by America's Health Insurance Plans (AHIP) found no legal barriers to the collection of race and ethnicity by health insurance plans.⁷ Additionally, AHIP reported that 87% of health plans nationwide, and 100% of those in Connecticut, already have the technical capability to collect race, ethnicity, and language at the point of enrollment.⁸

6. CMS included race, ethnicity, and language data fields in its Single Streamlined Application (SSA) to be used for health insurance exchange, Medicaid, and CHIP enrollment.⁹

DSG Data Elements – Claims

We support the DSG requirements for Denied Flag and Denial Reason and propose a level of granularity be required of Reporting Entities and subcontractors to provide information about claim denials that can have an impact (positive or negative) on the health of Connecticut's citizens, such as claims denied for: not covered/excluded benefit, benefit limits met, paid at lower level of benefit, prior approval denied, not FDA approved, step and quantity limits, out-of-network, investigational/experimental, waiting period not met, and not medically necessary. If adopted as drafted, Reporting Entities and subcontractors are not required to provide denial reason codes at a level of specificity useful for analyses of barriers to care across populations, providers, and conditions.

DSG Data Elements - Provider

The Provider Information Data File was not included in the July 24, 2013 Version 1.1 DSG available for public comment. We propose provider demographic data include provider race, provider ethnicity, provider language, and provider gender. Healthcare workforce diversity is an indicator of culturally competent care delivery.

⁶ U.S. Department of Health and Human Services, *Affordable Care Act to improve data collection, reduce health disparities*, June 29, 2011. Retrieved from <http://www.hhs.gov/news/press/2011pres/06/20110629a.html>.

⁷ AHIP, *A Legal Perspective for Health Insurance Plans: Data Collection on Race, Ethnicity, and Primary Language*, March 2009. Retrieved from <http://www.ahip.org/Race-Ethnicity-Language/>

⁸ Conversation B. Shipley, Health Disparities Institute and R. Carreon, AHIP, April, 2013.

⁹ U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services, *Announcement Details for Single streamlined application (Marketplace consumer application for QHP, APTC, Medicaid, and CHIP*, April 30, 2013. Retrieved from <http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Events-and-Announcements.html>

Respectfully,

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